CHAPTER 67

PSYCHOLOGICAL SERVICES MANUAL

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SUBCHAPTER 1. INTRODUCTION

10:67-1.1 Scope and purpose

(a) This chapter outlines the policies and the procedures of the New Jersey Medicaid program related to the provision of psychological services to Medicaid beneficiaries by psychologists in private practice reimbursed on a fee-for- service basis.

(b) This chapter does not apply to psychologists employed by State or County (Governmental) or private psychiatric hospitals, independent clinics, or to psychologists employed by residential treatment centers under contract with the Division of Youth and Family Services (DYFS) and/or the Division of Mental Health Services (DMHS).

10:67-1.2 Definitions

The following words and terms, when used in this manual, shall have the following meanings unless the context clearly indicates otherwise.

"CPT" means that edition of the Current Procedure Terminology most current at the time of reference, as published annually by the American Medical Association, Chicago, Illinois, unless otherwise specified in rule.

"Nursing facility (NF)" means an institution (or distinct part of an institution) certified by the New Jersey State Department of Health and approved for participation in Medicaid and primarily engaged in providing:

1. Nursing care and related services for patients who require medical, nursing care, and social services;

2. Rehabilitative services for the rehabilitation of the injured, disabled, or sick; or

3. Health-related care and services on a regular basis to patients who because of a mental or physical condition require care and services above the level of room and board. However, the nursing facility is not primarily for the care and treatment of patients with mental diseases which require continuous 24-hour supervision by qualified mental health professionals.

"Physician", for the purpose of participation in the New Jersey Medicaid program, means exclusively a doctor of medicine (M.D.) or osteopathy (D.O.) licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners, or similarly licensed by comparable agencies of the state in which he or she practices.

"Psychological services" means those services rendered within the scope of the profession of psychology as defined by the laws of the State of New Jersey or by the laws of the state in which the psychologist practices.

"Psychological specialist" means a psychologist who limits his or her practice to his or her specialty and who:

1. Is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified); or

2. Has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

"Psychologist" means a practicing professional psychologist who is licensed by the New Jersey State Board of Psychological Examiners or by the comparable state agency in the state in which he or she practices.

"Residential health care facility" means a facility, licensed by the New Jersey State Department of Health, which furnishes food and shelter to four or more persons 18 years of age and older who are unrelated to the owner and which provides dietary services, recreational activities, supervision of self- administration of medications, supervision of and assistance in activities of daily living (ADL) and assistance in obtaining health services to one or more of such persons. As used in this chapter, the term "residential health care facility" means a "boarding home for sheltered care" as defined by the New Jersey State Department of Health.

"Residential treatment center" means a facility that:

1. Has a facility or program accreditation by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO);

2. Provides 24-hour per day care and treatment for recipients under 22 years of age whose needs are such that they are unable to function appropriately in their homes, schools and communities, and are not able to be served appropriately in less restrictive setting; and

3. Has signed a provider agreement to participate in the Medicaid program and abide by the rules of the Division.

10:67-1.3 Conditions of participation

(a) To be approved as a Medicaid provider by the New Jersey Medicaid program, the psychologist or psychologist specialist shall:

1. Complete and submit the Medicaid "Provider Application" (FD-20) and the "Medicaid Provider Agreement" (FD-62).

i. The documents, referenced in (a)1 above, are located as Forms #8 and #10 in the Appendix of the Administration Chapter (N.J.A.C. 10:49--Appendix) at the end of the chapter, and may be obtained from and submitted to:

Unisys Corporation

Provider Enrollment

PO Box 4804

Trenton, New Jersey 08650-4804

ii. Provider agreements are approved by the:

Chief, Provider Enrollment Unit

Division of Medical Assistance and Health Services

PO Box 712

Trenton, New Jersey 08625-0712

2. To be approved by the New Jersey Medicaid program as a psychological specialist, the psychological specialist shall enclose with the provider application, documentation that he or she:

i. Is a Diplomate of the American Board of Professional Psychology (Diplomate Qualified); or

ii. Has been notified of admissibility to the examination by the American Board of Professional Psychology (Diplomate Eligible).

(b) If the psychologist is providing psychological services to a Medicaid recipient residing in a nursing facility (NF), or residential health care facility, or a residential treatment center, these facilities shall be Medicaid approved facilities.

(c) Upon approval as a psychological services provider, the psychologist shall be assigned a Medicaid provider number.

(d) Upon enrollment, the fiscal agent shall furnish a provider manual and an initial supply of pre-printed claim forms.

10:67-1.4 Recordkeeping

(a) Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, HCFA Common Procedure Coding System).

(b) For the initial examination, the record shall include, as a minimum, the following:

1. Date(s) of service rendered;

2. Signature of the psychologist;

3. Chief complaint(s);

4. Pertinent historical, social, emotional, and additional data;
5. Reports of evaluation procedures undertaken or ordered;

6. Diagnosis; and

7. The intended course of treatment and tentative prognosis.

(c) For subsequent progress notes made for each Medicaid patient contact, the following shall be included on the psychotherapeutic progress note:

1. Date(s) and duration of service (for example, hour, half-hour);

2. Signature of the psychologist;

3. Name(s) of modality used, such as individual, group, or family therapy;

4. Notations of progress, impediments, or treatment complications; and

5. Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.

6. One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):

i. Symptoms and complaints;

ii. Affect;

iii. Behavior;

iv. Focus topics; and

v. Significant incidents or historical events.

10:67-1.5 Basis of reimbursement

(a) Psychological services shall be reimbursed at the lesser of the psychologist's charges or the amount in the Medicaid Maximum Fee Allowance Schedule for psychological services. (See N.J.A.C. 10:67-3.2 for the Maximum Fee Allowance Schedule.)

(b) The Medicaid Maximum Fee Allowance Schedule is based on the Health Care Financing Administration Common Procedure Coding System (HCPCS). For HCPCS codes and Maximum Fee Allowance Schedule, see N.J.A.C. 10:67-3. For billing instructions, see the Fiscal Agent Billing Supplement in the Appendix of this chapter.

(c) In no event shall the provider's charge to the New Jersey Medicaid program exceed the charge for services rendered by the provider for identical services to other governmental agencies, or other groups or individuals in the community.

10:67-1.6 Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D fee-for-service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is $5.00 a visit for all types of psychological services.

1. Psychological services includes services provided in the office, patient's home, or any other site, except a hospital, where the child may have been examined or treated by the psychologist.

(c) There shall be a $5.00 copayment per visit for psychology services for Plan D enrollees.

(d) Psychologists shall collect the copayment specified. Copayments shall not be waived.

END OF SUBCHAPTER 1

SUBCHAPTER 2. GENERAL PROVISIONS

10:67-2.1 General provisions

(a) Psychological services reimbursed directly to the psychologist may be provided in settings such as an office, home, general hospital (inpatient), residential health care facility, nursing facility, or residential treatment center that is not enrolled as an approved Medicaid provider.

(b) The New Jersey Medicaid program will not reimburse for services supervised by, but not performed by the psychologist in any setting. Only the psychologist who personally renders the psychological service will be reimbursed.

(c) The special reimbursement for psychological services will be rendered if the provider meets the specialist requirements as defined in N.J.A.C. 10:67- 1.2 and 1.3.

(d) Except for psychological testing or exceptional circumstances which are documented in the patient's medical record, only one psychological service shall be reimbursed per day for the same beneficiary by the same provider, group, shared health care facility, or practitioners sharing a common record.

(e) Payment for a psychological evaluation shall include all psychological services provided on that day. No additional reimbursement will be made for psychotherapy on the day that a psychological evaluation is provided.

(f) "Consultation" or "concurrent care" shall not be billed by a psychologist specialist for his or her services as a specialist. If a referral from a psychologist to a psychiatrist is indicated, the psychiatrist may be reimbursed under the provisions of "consultation" or "concurrent care" in the Physician Services Manual (N.J.A.C. 10:52) in addition to the psychologist bill, but not vice versa.

10:67-2.2 Provisions for services rendered in specific settings including institutional settings

(a) Psychological services rendered to a Medicaid patient by an approved community mental health agency or by an approved independent clinic, or under the auspices of such agency or facility, or by a hospital outpatient department shall be billed directly by the agency or clinic.

1. All psychological services rendered to a patient of a hospital outpatient department shall be considered hospital costs, whether or not the psychologist receives compensation from the hospital.

(b) A psychologist employed and/or under contract with a facility including a general hospital, a private psychiatric or State or County (Government) psychiatric hospital, an intermediate care facility/mental retardation, or a residential treatment center (that has a provider agreement with the New Jersey Medicaid program) may not bill directly for psychological services provided to Medicaid patients.

(c) When psychological services are provided to persons in a nursing facility, payment will not be made for any services rendered by an owner, administrator, stockholder of the company or corporation, or any person who has a direct financial interest in the institution.

10:67-2.3 Prior authorization

(a) Prior authorization means approval of the psychological service before the service is provided. For general information about prior and retroactive authorization, see N.J.A.C. 10:49-6.1--Administration.

1. Prior authorization is required for psychological services provided to a Medicaid patient residing in a nursing facility, or in a residential health care facility (as described in (b) below), or in either a community setting, or a residential treatment center, as described in (c) below.

(b) Prior authorization is required for psychological services provided to a Medicaid patient residing in a nursing facility (NF) or residential health care facility (RHCF), when payment to the psychologist for the services rendered reaches and/or exceeds $400.00 in any 12 month service year, commencing with the initial visit. (For definitions of NF or RHCF, see N.J.A.C. 10:67-1.2.)

1. The request for prior authorization of psychological services provided to a Medicaid patient residing in a nursing facility shall be submitted directly to the appropriate Medicaid District Office serving the nursing facility (see (d) below).

2. The request for prior authorization of psychological services provided to a Medicaid patient residing in a residential health care facility shall be submitted directly to the Mental Health Services Unit (for address, see (d) below).

3. Authorization for psychological services for a Medicaid patient residing in a nursing facility or residential health care facility may be granted for a maximum period of three months. Additional authorizations may be requested, based on continued medical necessity, as indicated in the request for additional authorization.

(c) Prior authorization is required for psychological services provided to a Medicaid patient residing in a community setting, or in a residential treatment center (that has not signed a provider agreement with the Medicaid program) when payment for the services reaches and/or exceeds $900.00 in any 12 month service year, commencing with the initial visit. The request for the prior authorization must be submitted directly to the Mental Health Services Unit (see (d) below for address).

1. Authorization for psychological services in the community may be granted for a maximum period of one year. Additional authorizations may be requested.

(d) The request for prior authorization shall be submitted on the Form FD-07 (Request for Prior Authorization for Mental Health Services). See the Fiscal Agent Billing Supplement following this chapter for a sample of the FD-07 form, for instructions to complete it, and for information about the need for the authorization number on the claim form.

1. A request for reauthorization shall include a summary progress note and a detailed treatment plan in the form of a progress note. This information shall be included in, or attached to, the FD-07 form.

2. Although the completed FD-07 form is to be submitted to either the appropriate Medicaid District Office (MDO) or the Mental Health Services Unit, as applicable (see (b) and (c) above), the Medicaid fiscal agent will notify the provider, in writing, as to the disposition of the request for prior authorization. An MDO Directory is provided in the Appendix of N.J.A.C. 10:49, Administration. The Mental Health Services Unit address is as follows:

Mental Health Services Unit

Office of Health Service Administration

Division of Medical Assistance and Health Services

Mail Code #15

PO Box 712

Trenton, New Jersey 08625-0712

3. The Medicaid fiscal agent will notify the provider in writing as to the disposition of the request for prior authorization.

4. An opportunity for a fair hearing may be granted to any provider requesting a hearing on any complaint or issue arising out of the claims payment process, in accordance with N.J.A.C. 10:49-10, Notices, Appeals and Fair Hearings.

END OF SUBCHAPTER 2

SUBCHAPTER 3. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS) CODE AND MAXIMUM FEE SCHEDULE FOR PSYCHOLOGICAL SERVICES

10:67-3.1 Introduction

(a) The New Jersey Medicaid program uses the Health Care Financing Administration's (HCFA) Common Procedure Code System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedure Terminology-- 4th Edition (CPT-4) (CPT) architecture, employing a five-position code and as many as two-position modifiers. Unlike the CPT numeric design, the HCFA- assigned codes and modifiers contain alphabetic characters. Because of copyright restrictions, the CPT procedure narratives for Level I codes are not included in this manual, but are hereby incorporated by reference. Copies may be obtained from the American Medical Association, PO Box 10950, Chicago, Illinois 60610, attention: Order Department. The HCPCS codes are relevant to Medicaid psychological services and must be used when filing a claim. Listed below are some of the general policies of the New Jersey Medicaid program regarding HCPCS.

1. The use of a procedure code will be interpreted by the New Jersey Medicaid program as a representation that the psychologist personally furnished, as a minimum, the service for which it stands.

(b) When submitting a claim, the psychologist must always use his/her usual and customary fee. The MEDICAID MAXIMUM FEE ALLOWANCE designated for any HCPCS code represents the New Jersey Medicaid program's maximum payment for the given procedure.

1. All references to time parameters shall mean the psychologist's personal time in reference to the service rendered unless it is otherwise indicated.

2. The information under the "QUALIFIER" refers the provider to information concerning the New Jersey Medicaid's program qualifications and requirements when a procedure or services code is used.

(c) The psychological services use exclusively Level I HCPCS codes of a three- level coding system, as follows:

1. Level I codes: Narratives for these codes are found in CPT, which is incorporated herein by reference, as amended and supplemented. The codes are adapted from CPT for use primarily by the psychologist. Level I procedure codes, and fees for each, for which the psychologist may bill, can be found at N.J.A.C. 10:67-3.2.

(d) Specific elements of HCPCS codes require the attention of providers. The lists of HCPCS code numbers for psychologist services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND" "HCPCS CODE" "MOD", "DESCRIPTION", "FOLLOW-UP DAYS" and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

1. Alphabetic and numeric symbols under "IND" & "MOD": These symbols, when listed under the "IND" and "MOD" columns, are elements of the HCPCS coding system used as qualifiers or indicators ("IND" column) and as modifiers ("MOD" column). They assist the provider in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required for reimbursement purposes.

i. These symbols and/or letters shall not be ignored, because they reflect requirements, in addition to the narrative which accompanies the CPT/HCPCS procedure code as written in the CPT, for which the provider is liable. These additional requirements shall be fulfilled before reimbursement is requested.

ii. If there is no identifying symbol listed, the CPT/HCPCS procedure code narrative prevails.

IND lists alphabetic symbols used to refer the provider to information concerning the New Jersey Medicaid program's qualifications and requirements when a procedure or service code is used. An explanation of the indicators and qualifiers used in this column is located below and in paragraph 1, "Alphabetic and numeric symbols," as follows:

"P" = preceding any procedure code indicates that prior authorization shall be required. The appropriate form that must be used to request prior authorization is indicated in the Fiscal Agent Billing Supplement.

"N" = preceding any procedure code means that qualifiers are applicable to that code. (See also N.J.A.C. 10:67-2.3 for the specific limitations of the total dollar amounts for services within a specific timeframe for a specific Medicaid beneficiary.)

HCPCS
CODE = HCPCS procedure code numbers.

MOD = Alphabetic and numeric symbols: Under certain circumstances, services and procedures may be modified by the addition of alphabetic and/or numeric characters at the end of the code.

"22" = Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding the modifier "22" to the usual procedure number. A report with additional documentation must accompany the claim form to justify the greater services, unusual services or complications.

(e) Listed below are general policies of the New Jersey Medicaid program that pertain to HCPCS. Specific information concerning the responsibilities of a psychologist when rendering Medicaid-covered services and requesting reimbursement are located at N.J.A.C. 10:67-1.4, Recordkeeping; N.J.A.C. 10:67-1.5, Basis of reimbursement; and N.J.A.C. 10:67-2, General provisions.

1. General requirements are as follows:

i. When filing a claim, the appropriate HCPCS procedure codes must be used, in conjunction with modifiers when applicable.

ii. When billing, the provider must enter on the claim form a CPT/HCPCS procedure code as listed in N.J.A.C. 10:67-3.2.

iii. Date(s) of service(s) must be indicated on the claim form and in the provider's own record for each service billed.

iv. The "MAXIMUM FEE ALLOWANCE" as noted with these procedure codes represents the maximum payment for the given procedure for the psychologist and psychologist specialist. When submitting a claim, the psychologist must always use her or his usual and customary fee.

v. The use of a procedure code will be interpreted by the New Jersey Medicaid program as evidence that the practitioner personally furnished, as a minimum, the services for which it stands.

10:67-3.2 HCPCS Codes and reimbursement rates for psychological services (Level I)

HCPCS		Maximum Fee Allowance	
IND	Code	S	$ NS
N	90801	$37.00	$26.00
N	90804	$19.00	$13.00
N	90806	$37.00	$26.00
N	90847	$37.00	$26.00
N	90847-22	$46.00	$32.00
N	90853	$ 8.00	$ 6.00
N	90887	$19.00	$13.00
N	96100	$37.00	$26.00
N	96105	$37.00	$26.00
N	96111	$37.00	$26.00
N	96115	$37.00	$26.00
N	96117	$37.00	$26.00

10:67-3.3 HCPCS Code qualifiers for psychological services

Code	Narrative
90801	Initial Comprehensive Psychiatric Evaluation
	QUALIFIER: A Medicaid/NJ KidCare provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 50 minutes of direct clinical involvement with the patient or family member. No more than one claim is reimbursable per the same patient, per the same physician, per year.
90804	Individual Psychotherapy--approximately 20 to 30 minutes face-to-face with the patient
	QUALIFIER: This code requires for reimbursement purposes a minimum of 20 minutes of direct personal clinical involvement with the patient or family member.
90806	Individual Psychotherapy-- approximately 45 to 50 minutes face-to-face with the patient
	QUALIFIER: This code requires for reimbursement purposes a minimum of 45 minutes of direct personal clinical involvement with the patient or family member.
90847	Family Therapy--50 minute session
	QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 50 minutes of direct personal clinical involvement with the patient or family member.
90847-22	Family Therapy--80 minute session
	QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 80 minutes of direct personal clinical involvement with the patient or family member.
90853	Group psychotherapy by a psychologist (other than of a multiple family group).
	QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This code requires for reimbursement purposes a minimum of 90 minutes per session. One unit equals 90 minutes for each person in the group with the maximum of eight persons in the group.

90887 Family Conference--25 minute session
QUALIFIER: A Medicaid provider who is a psychologist may bill this physician procedure code for parallel psychological services. This procedure code must be used in conjunction with the treatment of the patient. This code requires for reimbursement purposes a minimum of 25 minutes of direct personal clinical involvement with the patient or family member. The CPT narrative otherwise remains applicable.

96100 Psychological testing with a written report per hour.
QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.

96105 Assessment of aphasia with a written report per hour.
QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.

96111 Extended developmental testing with a written report per hour.
QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.

96115 Neurobehavioral status exam with a written report per hour.
QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.

96117 Neuropsychological testing battery with a written report per hour.
QUALIFIER: The rate per hour includes time for interpretation and reporting the results of the psychological testing, including the cost of administration of the test and the scoring.

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Provider Services Unit

P.O. Box 4804

Trenton, New Jersey 08650-4804

or contact:

Office of Administrative Law

Quakerbridge Plaza, Building 9

CN 049

Trenton, New Jersey 08625-0049